

UNITED STATES DISTRICT COURT  
WESTERN DISTRICT OF LOUISIANA

In Re: Actos (Pioglitazone) Products  
Liability Litigation

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6:11-md-2299

This Document Applies to:

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JUDGE DOHERTY

MAGISTRATE JUDGE HANNA

ACTOS® PLAINTIFF FACT SHEET

Each plaintiff who alleges personal injury as a result of taking ACTOS®, ACTOplus Met®, ACTOplus Met XR®, Duetact®, and/or any other medication containing pioglitazone hydrochloride approved for sale and marketing in the United States (collectively referred to as “Actos®”) must complete a Fact Sheet. If you are completing this Fact Sheet in a representative capacity on behalf of someone who has died or who otherwise cannot complete the Fact Sheet, please answer as completely as you can for that person.

In completing this Fact Sheet, please use the following definitions: (1) “you” refers to the person who used Actos®, unless otherwise specified; (2) “healthcare provider” means any hospital, clinic, medical center, physician's office, urgent care center, infirmary, laboratory, or other facility that provides medical care or advice, and any pharmacy, physical therapist, rehabilitation specialist, physician, osteopath, homeopath, chiropractor, nurse, herbalist, nutritionist, dietician, or any other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you; and (3) “document” means any writing or record of any type in your possession or the possession of your attorney, including, but not limited to, written documents, e-mails, cassettes, videotapes, DVDs, photographs, medical records, charts, computer discs, tapes, or CDs, x-rays, drawings, graphs, non-identical copies, and other data from which information can be obtained and translated, if necessary, through electronic devices into a reasonably usable form. **You may attach as many sheets of paper as necessary to fully answer these questions.**

If you have any documents (as defined above), including, but not limited to, packaging, labeling, or instructions for Actos®, materials or items that you are requested to produce as part of answering this Fact Sheet or that relate to Actos®, or that relate to the injuries, claims, and/or damages that are the subject of your complaint, you must NOT dispose of, alter, or modify these documents or materials in any way. You are required to give all of these documents and materials to your attorney as soon as possible. If you are unclear about these obligations, please contact your attorney.

In completing the Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. You must supplement your responses if you learn that they are incomplete or incorrect.

Exhibit “A”

**I. Case Information**

A. Your Attorney's Name: \_\_\_\_\_

Firm: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

B. If you are completing this Fact Sheet in a representative capacity (on behalf of the estate of a deceased person or a minor), please complete the following:

1. Your name: \_\_\_\_\_

2. Your address: \_\_\_\_\_  
\_\_\_\_\_

3. The individual/estate you are representing: \_\_\_\_\_

4. Your relationship to that individual/estate: \_\_\_\_\_

5. If you were appointed as a representative by a court, please state the:

Court that appointed you: \_\_\_\_\_

Date of appointment: \_\_\_\_\_

The names of any other representatives appointed by the Court: \_\_\_\_\_  
\_\_\_\_\_

6. If you represent a decedent's estate, please state the:

Date of the decedent's death: \_\_\_\_\_

Place of the decedent's death: \_\_\_\_\_

THE REMAINDER OF THIS FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO USED ACTOS®. IF YOU ARE COMPLETING THIS FACT SHEET FOR SOMEONE ELSE, PLEASE ASSUME THAT "YOU" MEANS THE ACTOS® USER.

**II. Personal Information for the Actos® User**

A. Name: \_\_\_\_\_

B. Have you ever used any other names and, if so, when: \_\_\_\_\_  
\_\_\_\_\_

C. Address: \_\_\_\_\_

How long have you lived at this address? \_\_\_\_\_

D. Social Security Number: \_\_\_\_\_

E. Date and place of birth: \_\_\_\_\_

F. Sex: Male: \_\_\_\_\_ Female: \_\_\_\_\_

G. Ethnicity: African-American \_\_\_\_\_ Caucasian \_\_\_\_\_ Hispanic \_\_\_\_\_ Native American \_\_\_\_\_

Other (please specify) \_\_\_\_\_

H. Marital Status: \_\_\_\_\_

I. Spouse's name and date of marriage: \_\_\_\_\_

Has your spouse filed a loss of consortium or other claim in connection with this lawsuit?

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

J. If you have children, please state each child's name and date of birth: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

K. Have you ever served in any branch of the military? Yes \_\_\_\_\_ No \_\_\_\_\_

1. If yes, branch and dates of service: \_\_\_\_\_

2. Were you ever rejected or discharged from military service for any reason related to your medical, physical, or psychiatric condition? Yes \_\_\_\_\_ No \_\_\_\_\_

3. If yes, state the reason and date: \_\_\_\_\_  
\_\_\_\_\_

## L. Education:

1. Provide the following information regarding your education, beginning with high school and continuing through your highest level of education:

Name of School	City/State	Degree awarded and/or area of study/major	Dates of Attendance

M. Are you currently employed? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please identify your current employer with name, address, and telephone number, and your occupation: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

If not, did you leave your last job for a medical reason? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, describe why you left: \_\_\_\_\_

\_\_\_\_\_

Are you making a claim for lost wages or lost earning capacity? Yes \_\_\_\_\_ No \_\_\_\_\_

- N. Please complete the following information regarding any employers (other than your current employer) that you have had in the last ten (10) years, or at any time since your first ingestion of Actos®, whichever is longer:

Name of Employer	Address & Phone No.	Job Title/Duties	Dates Employed

- O. During the previous ten (10) years, or at any time since your first ingestion of Actos®, whichever is longer, have you been out of work for more than thirty (30) days during any calendar year for reasons related to your health (medical, physical, psychiatric or emotional condition)?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please state the dates, employer, and health condition: \_\_\_\_\_

- P. Identify each insurance carrier with whom you have had health insurance coverage at any time during the past ten (10) years:

Insurance Company	Policy Number	Policy Holder	Dates of Coverage

- Q. Have you ever received Medicare, Medicaid or other government medical benefits within the past ten (10) years? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe the benefits received: \_\_\_\_\_

- R. Have you applied for workers' compensation, social security, and/or state or federal disability benefits within the past ten (10) years? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, then as to each application, separately state:

1. Date (or year) of application: \_\_\_\_\_

2. Nature of the claimed injury/disability: \_\_\_\_\_

3. The agencies to which you submitted your application: \_\_\_\_\_

- S. At any point during the previous ten (10) years, have you ever been convicted of, or pled guilty to, a felony? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe the charge to which you pled guilty or were convicted of, the court, and the outcome: \_\_\_\_\_

T. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please state the following:

1. Party you sued or made a claim against: \_\_\_\_\_
2. Court in which suit was filed: \_\_\_\_\_
3. Case/claim number: \_\_\_\_\_
4. Attorney who represented you: \_\_\_\_\_
5. Nature of injury/claim: \_\_\_\_\_

### III. Use of Actos®

Date(s) of Use	Medication Prescribed	Dose	Name and Address of Prescribing Physician	Name and Address of Dispensing Pharmacy or where Actos was obtained

A. Do you currently use Actos®? Yes \_\_\_\_\_ No \_\_\_\_\_

B. Has any healthcare provider recommended that you not use Actos® or that you discontinue your use of Actos®? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, state the name and address of the healthcare provider and the date the recommendation was made: \_\_\_\_\_

\*If any such advice or recommendation was given in writing, please attach a copy.

C. Did you ever receive any samples of Actos®? Yes \_\_\_\_\_ No \_\_\_\_\_

If you answered yes, please state the following:

1. Who provided the samples? \_\_\_\_\_
2. When were the samples provided? \_\_\_\_\_
3. Did you request to any healthcare provider that he or she prescribe you Actos®?  
Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, which healthcare provider(s)? \_\_\_\_\_

- D. Have you had any direct communication, written or oral, with Takeda Pharmaceutical Company, Takeda Pharmaceuticals U.S.A., Inc. (formerly known as Takeda Pharmaceuticals North America, Inc.), Takeda Pharmaceuticals America, Inc., and/or Eli Lilly and Company or any of their representatives?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe the communication and the approximate date(s) on which it occurred:

\_\_\_\_\_  
\_\_\_\_\_

- E. Did you ever receive any written and/or oral information about Actos®? Yes \_\_\_ No \_\_\_

If yes, please specify the information you received: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

If yes, who provided this information? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

- F. Have you ever received assistance through a Patient Assistance Program for Actos®?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please identify the approximate dates during which you received assistance through the \_\_\_\_\_ program:

\_\_\_\_\_

- G. Have you ever visited a website, chatroom, message board, or other electronic forum containing information or discussion about Actos®? Yes \_\_\_\_\_ No \_\_\_\_\_ Unsure \_\_\_\_\_

If yes, please provide the name of the website(s): \_\_\_\_\_

\_\_\_\_\_

If yes, please identify the approximate date(s) on which you visited the website(s): \_\_\_\_\_

\_\_\_\_\_

**IV. Healthcare Providers and Pharmacies**

- A. Identify the following for each healthcare provider with whom you have consulted during the previous ten (10) years, or five (5) years prior to your first ingestion of Actos®, whichever is longer, to the present (or, if you are a minor, please list all healthcare providers):

<b>Name &amp; Specialty</b>	<b>Address &amp; Phone Number</b>	<b>Dates of Treatment (Provide approx date(s) if precise date(s) are unknown)</b>	<b>Reason for Treatment</b>

- B. Identify the following for each time you were hospitalized and/or received treatment in an emergency room or an out-patient setting during the previous ten (10) years, or five (5) years prior to your first ingestion of Actos®, whichever is longer, to the present (or, if you are a minor, please list all hospitalizations):

<b>Name of Facility</b>	<b>Address &amp; Phone Number</b>	<b>Dates of Treatment (Provide approx date(s) if precise date(s) are unknown)</b>	<b>Reason for Treatment</b>



- C. Identify the following for each pharmacy, drug store and/or other supplier (including mail order and internet pharmacies) where you have filled prescriptions during the previous ten (10) years, or five (5) years prior to your first ingestion of Actos®, whichever is longer, to the present (or, if you are a minor, please list all pharmacies or other medication suppliers):

Name	Address & Phone Number

**V. Injuries and Damages Alleged**

- A. Are you claiming that you suffered bodily injury as a result of taking Actos®?

Yes \_\_\_\_\_ No \_\_\_\_\_

If you answered yes, please identify and describe your alleged injury(ies) and dates of diagnosis:

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B. To the extent not set forth in Section IV.A and IV.B above, please identify the following information for the healthcare providers who rendered care and treatment to you for the injury(ies) you allege above:

Name & address of Healthcare Provider(s) who rendered care and treatment to you for alleged Injury(ies)	Reason for Treatment

C. Has any healthcare provider told you that any of your alleged injury(ies) are the result of your use of Actos®? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, provide the healthcare provider's name and address and the approximate date of this conversation: \_\_\_\_\_

\_\_\_\_\_

D. Did you ever experience the type of injury or injury(ies) you allege were caused by Actos® prior to the date(s) set forth above? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please identify which injury(ies) and when you experienced them: \_\_\_\_\_

\_\_\_\_\_

If yes, please identify any healthcare provider(s) with whom you have treated for this alleged injury, including their name and address: \_\_\_\_\_

\_\_\_\_\_

E. Are you claiming that you have paid, or will have to pay, any monetary expenses or fees for medical treatment as a result of having taken Actos®? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

F. Are you claiming in this case that you suffered psychiatric or psychological injury as a result of your use of Actos®? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please describe: \_\_\_\_\_

If yes, please identify any healthcare provider(s) with whom you have treated for this alleged injury, including their name and address: \_\_\_\_\_

## VI. Medical Background of the Actos® User

A. Current Height \_\_\_\_\_ Current Weight \_\_\_\_\_

### B. Smoking History:

1. Have you ever smoked cigarettes? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, when did you smoke? \_\_\_\_\_

If yes, how many cigarettes/packs per day/week? \_\_\_\_\_

Have your smoking habits changed over time? \_\_\_\_\_

2. Do you currently smoke cigarettes? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, how much do you currently smoke? \_\_\_\_\_

### C. Alcohol History:

1. Do you currently drink alcohol (beer, wine, liquor, etc.)? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, how many drinks per week/month/year? \_\_\_\_\_

2. During the previous ten (10) years, have you consumed alcohol? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, during what period of time did you consume alcohol?

How many drinks per week/month/year did you consume?

### D. Use of Illicit Drugs:

1. During the previous ten (10) years, have you used any illicit drugs of any kind (such as cocaine, crack, heroin, or LSD) without a prescription? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, which drug(s)? \_\_\_\_\_

If yes, when? \_\_\_\_\_

E. Medical History: Have you ever been diagnosed with any of the following?

Condition	Yes	No	Unknown	Date of Diagnosis (Provide approx date(s) if precise date(s) are unknown)
Type II diabetes mellitus				
Type I diabetes mellitus				
Gestational diabetes				
Diabetic coma				
Diabetic ketoacidosis (DKA)				
Diabetic ketosis				
Hyperglycemia (high blood sugar)				
Glycosuria/glucosuria (sugar in your urine)				
Impaired fasting glucose, pre-diabetes				
Insulin resistance				
Metabolic syndrome				
Other problems related to blood sugar, glucose, ketones, or insulin				
High cholesterol				
High blood pressure				
Bladder cancer				
Other cancer (please specify below)				
Type(s) of cancer				
Bladder infection				
Urinary tract infection or blockage				
Enlarged prostate				
Hyperplasia				
Kidney disease				
Kidney stones				
Myocardial infarction				
Cerebrovascular disease, including stroke				
Coronary artery disease				
Congestive heart failure				

F. *Other than* those injuries that you believe were caused by your use of Actos®, do you currently suffer from any physical injuries or disabilities? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please identify:

The injury, illness, or disability: \_\_\_\_\_

Date(s) of onset: \_\_\_\_\_

Date(s) of diagnosis: \_\_\_\_\_

Name and address of treating physician: \_\_\_\_\_

## VII. Medications

Do you currently take, or have you ever taken, any of the following medications:

Medication	Yes	No	Unknown	If yes, dose and dates of usage (Provide approx date(s) if precise date(s) are unknown)
Metformin				
Avandia				
Rezulin				
Glucophage				
Fortamet				
Glyset				
Precose				
Prandin (Repaglinide)				
Starlix (Nateglinide)				
Lispro (Humalog)				
DiaBeta (Glyburide)				
Glargine/Lantus				
Glulinine				
Levemir (Detemir)				
Glucotrol (Glipizide)				
Amaryl (Glimepiride)				
Dymelor				
Glynase/PresTab				
Micronase				
Orinase				
Tolinase				
Symlin (Pramlintide)				
Januvia (Sitagliptin)				
Byetta (Exenatide)				
Other medications used to treat diabetes (specify )				
Cyclophosphamide (Cytoxan)				
Empirin compound				
Ifosfamide (Ifex)				
Phenacetin				
Aristolochia fangchi				

**VIII. Family Medical History**

To the best of your knowledge, please indicate whether your *parents, siblings, children or grandparents* have ever suffered from or been treated for any of the following:

Condition	Yes	No	Unknown	If yes, identify the family relationship(s)
Diabetes mellitus				
Hyperglycemia				
Glucose intolerance				
Cancer (If yes, please specify _____)				
Kidney disease				
Kidney stones				
Hyperplasia				
Enlarged prostate				

**IX. Fact Witnesses**

A. Other than your healthcare providers, please identify all persons whom you believe possess information concerning your alleged injury and/or other facts related to your claim:

Name	Address	Relationship to you

**X. Declaration**

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge, information and belief formed after due diligence and reasonable inquiry.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

**XI. Documents: These Document Demands are made pursuant to Fed.R.Civ.P. 34.**

- A. Please sign and attach to this Fact Sheet authorizations allowing for release of all relevant records. (Please be sure that either you or your attorney complete the top portion of each authorization form for each provider for whom an authorization is being provided).
- B. If completing this Fact Sheet on behalf of a deceased person, please attach the legal documentation establishing that you are the legal representative of the estate and the Decedent's death certificate and autopsy report (if applicable).
- C. Please indicate whether you or your counsel have any of the following materials in your possession by placing a checkmark next to the word "yes" or "no." **If yes, attach a copy of any such documents. In responding, note that Actos® is pioglitazone hydrochloride.**
  1. Medical records from any physician, hospital or healthcare provider for the previous ten (10) years or five (5) years prior to your first ingestion of Actos®, whichever is longer, to the present. Yes\_\_\_\_ No \_\_\_\_
  2. Pharmacy records for the previous ten (10) years or five (5) years prior to your first ingestion of Actos®, whichever is longer, to the present, including receipts, prescriptions or records of purchase. Yes\_\_\_\_ No\_\_\_\_
  3. Advertisements for Actos® or articles discussing Actos® which you reviewed before and during the time you took Actos®. Yes\_\_\_\_ No\_\_\_\_
  4. The packaging, including the box and label, for Actos® and any remaining medication (plaintiffs must retain the originals of the items requested). Yes\_\_\_\_ No\_\_\_\_
  5. Product use instructions, product warnings, package inserts, pharmacy handouts or other materials distributed with or provided to you in connection with your use of Actos®. Yes\_\_\_\_ No\_\_\_\_
  6. Any other documents or materials that mention Actos®, or any alleged health risks or hazards related to Actos® in your possession at or before the time of the injury alleged in your complaint.  
Yes\_\_\_\_ No\_\_\_\_
  7. Statements obtained from or given by any person, other than your attorney(s) or retained expert(s), having knowledge of facts relevant to the subject of this litigation.  
Yes\_\_\_\_ No\_\_\_\_
  8. Documents that were provided to you by any of the defendants. Yes\_\_\_\_ No\_\_\_\_

9. Documents constituting any communications or correspondence between you and any representative of the defendants. Yes\_\_\_\_ No\_\_\_\_
10. Photographs, drawings, journals, slides, videos, DVDs or any other media relating to your alleged injury or the quality of your life after developing the injury that you allege is the result of Actos®. Yes\_\_\_\_ No\_\_\_\_
11. If you claim you have suffered a loss of earnings or earnings capacity, your W-2s and/or any other tax records reflecting your income for each of the last five (5) years. Yes\_\_\_\_ No\_\_\_\_
12. If you claim you have suffered a loss of earnings or earnings capacity, all employment records in your possession, including employment applications, performance evaluations, paychecks and pay stubs for the five (5) years prior to the injury that you associate with Actos®, whichever is longer, to the present. Yes\_\_\_\_ No\_\_\_\_
13. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other healthcare provider documenting those medical expenses. Yes\_\_\_\_ No\_\_\_\_
14. If you have been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding that are in your possession. Yes\_\_\_\_ No\_\_\_\_
15. Journals, diaries, notes, letters, e-mails, tweets, Facebook posts, internet postings, and any other documents written or received by you (excluding communications to or from your attorney) within the previous ten (10) years which relate to Actos or the injuries you allege in this case. Yes\_\_\_\_ No\_\_\_\_
16. Print-outs of all websites or blogs which are maintained or created by you. Yes\_\_\_\_ No\_\_\_\_

## **XII. Certification of Counsel**

Undersigned counsel for plaintiff(s) (Counsel) certifies that Counsel and/or members or associates in Counsel's firm instructed Plaintiff(s), Plaintiffs' other current or former attorneys and/or agents for any of the foregoing, to engage in best efforts to identify, locate and supply all responsive documents demanded in the Request to Produce to Plaintiff(s) approved by Case Management Order: Plaintiff Fact Sheets (dated July 9, 2012) that were in the custody or control of Counsel, Plaintiff, Plaintiffs' other current or former attorneys and/or agents for any of the foregoing, and Counsel further certifies that Counsel has a good faith belief that these instructions were followed by all of the aforementioned persons.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_